ISSUE N° 60 SEPTEMBER 2025

WEST COAST VETERINARIAN

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FROM THE EDITOR

COREY VAN'T HAAFF
EDITOR

TO THE EDITOR

Letters from members are welcome. They may be edited for length and clarity. Email us at wcveditor@gmail.com.

ON THE COVER

Mission Pawsible veterinary clinic held in Anacla, BC, at the House of Huu-ay-aht. Photo by James Rodgers.

One of the glorious aspects of having the job of *West Coast Veterinarian* editor is seeing how others live or work. I learn how an emergency veterinarian experiences joy at work, fighting and hoping with her whole heart that she can get a patient home; or how a pathologist examines more than a million samples, all with the goal of helping patients to the best of his abilities. Or, in the case of returning contributor Dr. Klemmensen, I discover how biking—or bikepacking, as she calls it—with her dog strengthens her personal recipe for well-being.

There is nothing I have done a million times. There is no rough terrain or foreign land I've explored. Not even close. But within my entire being is a desire to get dogs home. [For those who may interpret my focus on dogs as a disinclination for other animals, know that I truly want the best for every animal; I use "dogs" somewhat generically here. However, dogs seem to uniquely connect with my heart and soul.]

As I sit in my enclosed front yard, contemplating my pond and the goldfish and minnows that explore the water while being alert for eagles so I can pick up my small dogs, I wonder: how am I strengthening my own recipe for well-being? I feel good about my life, my work, my family, and my dogs (and a cat who humours me and pretends to be a dog), but sometimes I wonder if I should be doing something bigger, something greater, something more noticeable.

Duty calls each of us differently. Some are called to greatness, some to serve, some to conquer, and some to nurture. Some to pave new pathways, while others enhance what already exists. For me, my goal—my pursuit of something—doesn't lie in a desire to try new things or old things in a different way, be it an educational pursuit, an outdoorsy adventure, or even a gastronomic exploration for company. For me, my personal recipe is consistent, focused, and soft—making a quiet difference, one person at a time.

And here's the thing: that is enough for me. Because for me, it all comes back to dogs. I stand ready to support veterinarians who might be experiencing a sudden lapse in confidence, feeling devastated or angry from a complaint, or simply needing an open ear to brainstorm, listen, recommend, advise, or plan. Go on. Be a weekend warrior, a veterinarian without borders, an explorer, an adventurer, a voyager. I love your pursuits, and I watch with great interest, but my place is here. I am comfortably ensconced here, at home, always ready to help veterinarians with whatever you need, whatever you call me to do, because I am always ready to get another dog home. WCV

Email: wcveditor@gmail.com

P.S. With this issue, we bid a fond farewell to my friend and our ad sales person, Inga Liimatta, whom I've worked with since the very first issue of WCV and known since my journalism days. Inga is whip smart, well-connected, and a delight to work with, and we wish her well as she joins her husband in retirement. She plans to spend much more time with family, exploring places to see and eat, and always, I hope, looking for something new to read.

WCV

WEST COAST VETERINARIAN ISSUE 60

West Coast Veterinarian is the quarterly magazine of the Society of British Columbia Veterinarians (SBCV)

WEST COAST VETERINARIAN

SBCV CVMA-SBCV Chapter

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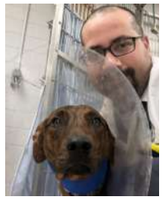
Please note, any visits are by appointment. Thank you for understanding.

As a provincial organization, the SBCV recognizes that its members occupy the traditional and unceded lands and territories of BC's Indigenous Peoples and asks its members to reflect on the places where they reside and work.

22
JAMES HERRIOT IS DEAD

SEPTEMBER



ASHLEE ALBRIGHT, BSc, DVM, is the co-owner of Peninsula Veterinary Hospital in Sidney, BC, and PenVet Mobile Veterinary Services. She splits her professional time between general practice hospital work and providing euthanasia services at home all over the Greater Victoria Region. Spending more time in clients' homes has been revitalizing as it offers a change of pace, facilitates client trust through deeper conversations, and allows pets to receive gentle end-of-life care while in their most vulnerable states. Building a new hospital and team to fill it has been the biggest professional challenge of her career and the most fulfilling. She lives in beautiful Brentwood Bay with her husband, two children, young Cavalier King Charles Spaniel, and senior cat. As a busy practice owner with a never-ending to-do list, she strives to prioritize living in the moment with those she loves most.

AMANDA BOOTH, BSc, DVM, MVSC, ACVIM (LAIM) but focusing only on small animals, began her studies in an advanced entry program at Lakehead University at the age of 13 and graduated at 17 years of age with her BSc, obtaining the highest average in the university and winning the Lieutenant Governor's Medal and the Dean of Science Medal. She began her veterinary studies that year at the Western College of Veterinary Medicine (WCVM) in Saskatoon, graduating in 1983. Interested in pursuing a more in-depth knowledge of internal medicine, she completed an Internship and Residency in Internal Medicine at the University of Pennsylvania and the WCVM and became a board-certified specialist with the American College of Veterinary Internal Medicine in 1990. Dr. Booth established Saseenos Veterinary Services in 1989 and has focused on building a team committed to medical excellence while keeping compassion for both patients and owners in the forefront. Outside of work, she spends her time spoiling her four-legged family members and training her Canadian Warmblood gelding, Red, in classical dressage.

ELAINE KLEMMENSEN, DVM, CEC, is always up for an adventure, especially if it involves people, pets, and creating connections in veterinary medicine. A self-described nerd about leadership, workplace culture, and organizational development, Dr. Klemmensen is a Certified Executive Coach holding the ACC-level certification with the International Coaching Federation as well as a certificate in Values-Based Leadership. Dedicated to helping veterinarians and their teams move from surviving to thriving, she founded Evolve Leadership Coaching and Consulting and is currently studying visual facilitation and strategic thinking. She lives in the beautiful West Kootenays and when not learning something new is most likely exploring the world by bicycle with her husband, Rob.

JULIA MILLER, PhD, DVM, is an assistant professor at the Faculty of Veterinary Medicine at the Wrocław University of Environmental and Life Sciences, where she combines her academic work with a passion for teaching and animal behaviour. She graduated with a DVM degree in 2008 and went on to earn her PhD in veterinary immunology in 2013. Julia is also a certified companion animal behaviourist, having completed postgraduate training in Companion Animal Psychology through the Polish Academy of Sciences in Warsaw and the Center of Applied Pet Ethology in Cracow. Her practical experience includes many years of working with shelter dogs and cats, providing behavioural support both in foster care and after adoption. Since 2022, Dr. Miller's research has focused on canine cognition, developed through ongoing collaborations with the Animal Welfare Program at the University of British Columbia.

JAMES RODGERS is credited as the cofounder of CARE Network, a small animal rescue and shelter operation near Tofino on Vancouver Island (if you meet James, ask him about the small, tenacious dog who really started CARE 15 years ago). In 2023, James and his team started Mission Pawsible, BC's first non-profit mobile veterinary practice. More recently, James also joined the Increased ACCESS team. The thread that runs through all of James' work is his passion to explore and innovate ways for everyone to be healthier and happier, together.

MARY VON DER PORTEN, BSc, MRM, DVM, is a veterinarian living and practising in the beautiful West Kootenays. Her background is in wildlife biology, extensively exploring the natural world before becoming a veterinarian. She has a BSc from University of Victoria, a Master's in Environmental and Resource Management from Simon Fraser University, and a DVM from the Western College of Veterinary Medicine. Dr. von der Porten juggles her time between private practice, two young children, skiing powder, riding horses, and trips to far-off places. She is passionate about sustainability and equality in veterinary medicine and is proud to be a volunteer veterinarian with Veterinarians Without Borders.

EWAN WOLFF, PhD, DVM, DACVIM (SAIM), is a small animal internist at Mountainside Animal Emergency & Specialty in North Vancouver. Having obtained their DVM degree from the University of Wisconsin (UW) School of Veterinary Medicine in 2011, Dr. Wolff stayed at UW as a rotating intern, then completed a small animal medicine residency and ACVIM Foundation Advanced Clinical Training Fellowship in nephrology/urology at Purdue University. Since 2018, Dr. Wolff has been an internist and has started medicine services at three practices, while previously serving as an internship director, house officer mentor, and resident research advisor. They also served on the BluePearl Science Study Design Review Committee and Institutional Review Board and, for several years, worked on innovation and strategy for the BluePearl University Partnership Program, a hybrid university-private practice faculty program launched in 2023. As an ACVIM volunteer, Dr. Wolff has contributed on its membership committee and to multiple DEI-B efforts. They are also a published author of scientific articles, chapters, and briefs on internal medicine, paleontology, mentorship, and DEI-B subjects. They previously served on the board of directors for the Pride Veterinary Medical Community as an industry liaison and co-authored and led the drive behind the Gender Identity Bill of Rights. They also serve on the board of visitors for the UW School of Veterinary Medicine. Outside of veterinary medicine, Dr. Wolff has been a research assistant professor for the University of New Mexico since 2019 and continues to work on paleopathology research.

Dear Colleagues and Friends,

I hope this letter finds each of you enjoying the beauty that a British Columbia autumn has to offer. As we move toward the end of the year, I want to take a moment to connect and share some recent updates and reflections.

First, the board and I had the privilege of meeting with the Honourable Lana Popham, Minister of Agriculture, to discuss the current situation for veterinarians here in BC regarding our provincial regulator and the governance of veterinarians as professionals. These conversations, led by the SBCV's provincial leadership, are vital for advocating for practical, long-term solutions that will benefit not just us as practitioners, but also the animals and communities we serve.

I also recently returned from the 2025 CVMA Convention, which was held in our own beautiful Victoria. It was a true delight to catch up with friends and colleagues from across the country and from every corner of our diverse industry. I had the honour of representing the SBCV at the annual presidents' meeting, where leaders from each province gathered to share our wins, losses, trials, and triumphs from the past year. Together, we tackled some of the major topics that continue to shape our profession: access to care, mental health and well-being, workforce shortages, the ongoing trend of corporate consolidation and its impact on veterinary practice—just to name a few. It's heartening to know that we are not alone in facing these challenges and that, together, we are committed to finding creative ways forward.

Of course, no convention would be complete without a bit of fun! We had a truly wonderful evening in the iconic and just-renovated (we were the first ones in) Bengal Room of the Empress Hotel, co-hosted by the SBCV and AVP. It was the perfect opportunity for BC veterinarians to come together, let our hair down, and reconnect in a relaxed and welcoming setting. Almost 100 veterinarians attended, and the food, drink, and conversations were lively and appreciated.

As we move through the rest of the year, I sincerely hope each of you can carve out some time for yourselves—whether with family or friends, in the outdoors, or simply a quiet moment to breathe. Let's do our best to make sure our cups are not just half full, but overflowing.

Thank you for all you do, every day, for our patients, clients, colleagues, and communities. It is an honour to serve as your president, and I look forward to continuing this important work alongside each of you.

Wishing you all a safe, restful, and joy-filled autumn. WCV

Fraser Davidson, BVSc, grew up in Vancouver and spent most of his childhood adventuring around the West Coast (mainly the Gulf Islands and Whistler). He is a dual citizen of both Canada and New Zealand, where he trained to become a veterinarian. He graduated in 2005 and spent five years working and travelling around Europe before moving back to Canada in 2010. He and his family moved to Squamish in 2017 and opened Sea to Sky Veterinary Clinic late in 2021. Dr. Davidson has two wonderful children, 11 animals, and an amazing, loving, and supportive wife.

As your CVMA President, it's my pleasure to update you on some of the CVMA's recent initiatives.

2026 CVMA AWARDS—NOMINATE A DESERVING COLLEAGUE

Each year, through its awards program, the CVMA proudly recognizes individuals who have demonstrated significant accomplishments, exemplary leadership, and tireless commitment to Canada's veterinary community. Nominations for the 2026 awards are accepted from November 1, 2025, until January 31, 2026. Award recipients receive complimentary registration to the 2026 CVMA Convention in Charlottetown, PE, along with other prizes specific to each award. Find more information on the CVMA Awards page in the About CVMA section of www.CanadianVeterinarians.net.

2025 ANIMAL HEALTH WEEK THEME ANNOUNCED

Animal Health Week (AHW) is an annual national public awareness campaign organized by the CVMA and celebrated by veterinary teams across Canada. Each year, the campaign highlights an important animal health-related message. The CVMA will promote the 2025 AHW theme, "Healing Hands, Caring Hearts: Every Animal Matters," from October 5 to 11. This year's theme celebrates the vital role veterinary professionals play in safeguarding animal well-being with empathy, expertise, and dedication. It emphasizes the importance of both technical skill and compassion in ensuring that every animal—regardless of species, size, or circumstance—is valued and cared for. Visit the Education and Events section of www.CanadianVeterinarians.net for more information.

CVMA HOSTS 2025 NORTH AMERICAN VETERINARY LEADERSHIP MEETING

In advance of its 2025 Convention in Victoria, BC, the CVMA hosted the 2025 North American Veterinary Leadership Meeting. Participants included representatives from the CVMA, American Veterinary Medical Association, Federación de Colegios y Asociaciones de Médicos Veterinarios Zootecnistas de México, and the American Association of Veterinary Medical Colleges who shared updates on current initiatives and collaborative efforts. Key topics of discussion included the veterinary technician spectrum of practice, rural practice initiatives, veterinary workforce challenges, and the ongoing impact of highly pathogenic avian influenza (HPAI).

THE WORKING MIND—COURSES

The Working Mind program addresses workplace mental health issues caused by inherent stresses such as day-to-day workflow pressures, interpersonal relationships, conflicts, and ethical and moral distress. Employees and managers who take this training have demonstrated increased resiliency skills and mental health well-being and a decrease in stigmatizing attitudes. Visit The Working Mind page of our website to learn more and register for upcoming courses. WCV

Tracy Fisher, DVM, grew up in Calgary, Alberta, but moved to Saskatchewan with her family in 1990. She graduated from the Western College of Veterinary Medicine in 1997 and has been practicing small animal and exotic medicine in Regina since then. Dr. Fisher has a special interest in avian and exotic animal medicine as well as soft tissue surgery. She also does a small amount of laboratory animal work for the University of Regina and a bit of wildlife rehabilitation work. Dr. Fisher and her business partner have recently sold their practice, and she continues to work as an associate in the hospital. Dr. Fisher has been involved with the Saskatchewan Veterinary Medical Association (SVMA) since graduation, serving on the Professional Promotion Committee, Discipline Committee, Legislation Committee, Centennial Committee, and Council with a term as President in 2004/2005. She has also served on the board of Prairie Diagnostic Services, as President of the Regina Association of Small Animal Practitioners, and is currently the SVMA representative for the University of Regina Senate, in addition to being the Saskatchewan representative on the CVMA Council. In her spare time, Dr. Fisher enjoys running, fishing, skiing, horseback riding, and many other outdoor activities. She and her husband, Rick, enjoy upland bird hunting and have bred and trained Large Munsterlanders. Their cat, Leonard, who tolerates the presence of everyone else in the house, is a fan of CVMA Zoom meetings and dutifully guards the house when they are away.

NEW BCVTA BOARD PRESIDENT

BY AMANDA BARKER, RVT, CVPP

I am honoured to introduce myself as the new President of the BC Veterinary Technologists Association (BCVTA) for the 2025–2027 term. Over the past four years, I've had the privilege of serving on the BCVTA Board as the CVBC Liaison. I've invested significant time into building a collaborative relationship with the CVBC Council and feel that my time has been well spent. As the incoming BCVTA president relocated unexpectedly, there wasn't adequate time to prepare a new CVBC Liaison. For continuity, I will continue serving in both roles.

As BCVTA President, my goals are to advance the regulation of RVTs in BC, prioritize initiatives that support RVT wellness and sustainability, and advocate for stronger recognition of the essential role RVTs play in veterinary health care. I'm also committed to expanding opportunities for mentorship and continuing education and to helping build a more connected and supportive veterinary community.

To achieve this, I draw on skills I've developed working as an RVT for the past 12 years, with experience spanning general practice, emergency medicine, wildlife rehabilitation, and specialty care. I've also gained valuable leadership experience throughout my career, managing teams in busy hospitals and serving on various industry boards and committees. These experiences, in addition to numerous professional certifications, have shaped my understanding of both the strengths and the challenges RVTs and veterinarians face in BC today. I'm consequently committed to creating a safe, fear-free environment for patients and clients, while also promoting mental health awareness and well-being across the veterinary field.

I look forward to what we can accomplish together as a community. As we begin the journey toward regulation, I hope to use my knowledge and experience working with the CVBC Council to build relationships with BC veterinarians and SBCV members to better understand how we can work together to develop a modern framework that raises the standard for RVTs and supports the workforce for better outcomes for our patients. WCV

> "THESE EXPERIENCES... HAVE SHAPED MY UNDERSTANDING OF BOTH THE STRENGTHS AND THE CHALLENGES RVTS AND VETERINARIANS FACE IN BC TODAY."

Amanda Barker, RVT, CVPP, BCVTA President (2025–2027), has spent 17 years in veterinary medicine, working her way from kennel assistant to RVT. She's experienced in general practice, wildlife rehabilitation, ECC, internal medicine, surgery, and anesthesia, and now co-owns and manages ORCA Orthopedic & Referral Centre on Vancouver Island. Certified in veterinary pain management, RECOVER CPR, and Fear Free, Amanda is passionate about mental health advocacy, spicy cats, and elevating care standards. She also runs a CPR training company and, outside of work, enjoys climbing, hiking, gym workouts, and life at home with her husband and three cats, Cougar, Hitch, and Moxie.

NAVIGATING LIFE AS A NEW GRADUATE IN BC

BY SHAWNA WILLIAMS, BSA

When we entered WCVM on the first day of our first year, we were told to keep an open mind for the future. We were instructed to stand up when our desired career focus was called out: small animal practice, mixed animal practice, large animal, equine, exotics, research, or a specialty program. After each of us had stood up for our rightful goals, we were told to expect them to change as we learned and grew through the four-year program. Expectations don't always align with reality. To get a sense of how life looks as a new graduate of veterinary medicine in BC, I spoke with several newly-minted veterinarians from the WCVM class of 2025, including a familiar face to regular readers—former SBCV Student Liaison, Dr. Fiona Lamb (Vancouver, BC).

When asked what factor they prioritized above all others when choosing their first job placement, the new graduates overwhelmingly answered "mentorship." As Dr. Aparna Chatterjee (Vancouver, BC) explained, "Strong mentorship is something I deeply value—not just in terms of case discussions, but also support around decision-making, client communication, and navigating the realities of veterinary medicine." New graduates want to feel included, accepted, and supported in their first positions so they can learn and grow in the field. We are told in school that it is not a matter of if we will make mistakes in our careers, but when, and in those moments the most important thing will be support and guidance. These factors are among the reasons that Dr. Eden Rowe (Victoria, BC) has chosen to pursue an internship in emergency medicine as her first job as a new graduate. "My expectations are that I get more clinical knowledge and experience in specialty and emergency medicine. I will be acting as the primary doctor, but with a lot of mentorship and guidance," Eden shared. Fiona also credits a large portion of her decision to pursue an internship to her desire for strong mentorship in her first year of clinical practice. "I saw an internship as the ideal way to broaden my clinical exposure and receive valuable mentorship from both specialists and emergency clinicians," expressed Fiona. It is safe to say that if a clinic is looking to attract a new graduate to their team, a strong foundation of mentorship is an essential piece of the puzzle.

In addition to mentorship and a desire to feel like their values align with those of their chosen clinic, new graduates also credit their fourth-year clinical rotations and summer jobs for steering them in the direction that best suits them. Dr. Gloria Hooshmand, originally from Saskatchewan, has chosen to begin her career in North Vancouver, BC, in small animal medicine, which is exactly what she thought she wanted to do when she started at WCVM four years ago. She credits her fourth-year clinical placements for guiding her decision. "Fourth year rotations helped reaffirm my decision and showed me what I don't want to do," Gloria shared. This sentiment is echoed by several of her classmates. Fiona explained, "During my clinical year, I particularly enjoyed my rotations in small animal internal medicine and ophthalmology, which inspired me to consider a path toward specialization." Eden took a different approach to using fourth-year rotations to set herself up for the beginning of her career: "I planned to do an internship, so this influenced what rotations I took. It did help me know that this clinic is where I would want to go as I did an external rotation here." Regardless of the approach, it is inarguable that time in-clinic during school is instrumental in preparing new veterinarians to start their careers.

The beginning of any new journey comes with many challenges and trepidations, as well as excitement and hopefulness. This is exactly what our new faces in veterinary medicine in BC are experiencing right now. Fiona spoke to this: "As a new graduate, I anticipated a steep learning curve. Veterinary medicine is a continuous learning process where adaptability is essential."

One of the biggest challenges many new graduates must overcome is actually self-imposed: imposter syndrome. When thrown into unfamiliar territory, it's difficult to roll through the day without fears of inadequacy. New graduates are shifting from asking their instructors what to do next to now being the ones who are looked to for decisions. On this topic, Aparna shared some words of wisdom for her fellow new veterinarians: "The imposter syndrome is very real coming out of vet school, and transitioning into the role of being a full-fledged veterinarian is very difficult. However, at the end of the day, we have to remind ourselves we worked very hard to get here and we have a lot of knowledge and enthusiasm that we bring to the table." Numerous new graduates expressed that they look forward to working with their new teammates to build their confidence and competency to shake off imposter syndrome. "One of my goals for my first year in practice is getting imposter syndrome in check!" shared Gloria.

It is a well-known fact that BC is feeling pressure to increase the number of veterinarians working in the province to support the demand on the industry. It is the hope of our new graduates that they will rise to the challenge, armed with fresh knowledge and enthusiasm. It sounds to me like they are more than ready to do so. To all the new graduates in veterinary medicine, BC wishes you all the best! WCV

"BC IS FEELING PRESSURE TO INCREASE THE NUMBER OF VETERINARIANS WORKING IN THE PROVINCE TO SUPPORT THE DEMAND ON THE INDUSTRY."

Shawna Williams, BSA, WCVM class of 2027, is originally from Fraser Lake, BC. Before beginning her journey at WCVM, she completed a Bachelor of Science in Agriculture with a major in Animal Science at the University of Saskatchewan College of Agriculture and Bioresources. She looks forward to exploring her interest in mixed-animal general practice, with a focus on large-animal medicine and surgery.

INTERNATIONAL RESEARCH PARTNERSHIPS: COLLABORATING TO IMPROVE DOG WELFARE

"I WAS ALSO INTERESTED TO LEARN ABOUT THE LARGE AMOUNT OF RESEARCH IN NORTH AMERICA ANALYZING REASONS FOR RELINQUISHMENT OR SURRENDER OF COMPANION ANIMALS TO SHELTERS."

BY JULIA MILLER, PhD, DVM

As a veterinarian and professor, I have studied veterinary immunology, focusing on the mechanisms of immune-mediated diseases in dogs. I have also worked in animal training and behavioural therapy and volunteered in animal rescue for many years. I became interested in learning more about behavioural science, which led me to the Animal Welfare Program (AWP). In 2022, I received a scholarship from the Dekaban Foundation, which promotes academic exchange between Poland and Canada. For that five-month scholarship, I collaborated with Dr. Alexandra Protopopova and AWP postdoctoral researchers and students in the Human-Animal Interaction (HAI) Lab. The HAI Lab conducts research to improve companion animal welfare in shelters, in pet-owning households, and in other roles, such as studying the well-being of therapy dogs.

This scholarship initiated an ongoing, fruitful collaboration. Since 2022, I have returned to the AWP twice more, contributing to projects exploring dog behaviour and cognition. For me, as a veterinarian, the most important aspect of our collaboration is the applied significance of our work. For example, our team investigated how positive mood affects dogs' learning capacity and stress resilience. We found that, contrary to our assumption, a walk (enriched in treats and play) before entering the lab did not improve learning or stress-resilience in a learning task, and we discussed some possible explanations in our recent publication (Miller et al., 2025). In another study, we examine how various guardian support strategies—such as offering treats or petting and verbal reassurance—impact dog behaviour and stress levels when facing a novel stimulus. Finally, this spring, we investigated dog attachment styles, and recruited dogs adopted as puppies and as adults to evaluate this aspect of the human-animal bond.

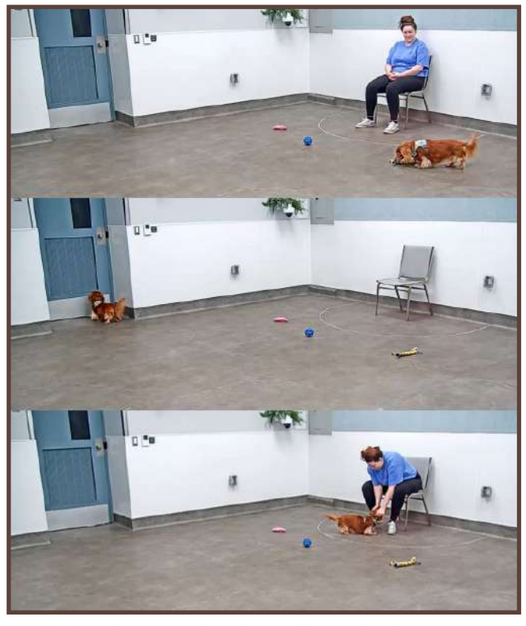


IMAGE 1: Secure base test is used to evaluate attachment styles in dogs. Canine behaviour is assessed during three phases: owner presence (top), brief separation (middle), and reunion (bottom).

Many of our research ideas stem from real-world challenges faced by dog trainers and animal rescue professionals. For instance, I was particularly motivated to study attachment styles due to a common belief that dogs adopted as adults cannot form as strong a bond with their new owners as those adopted as puppies. However, a questionnaire-based study I conducted in Poland earlier this year revealed that the perceived strength of the dog-owner bond does not depend on the age of the dog at adoption. To expand on this, our current study addresses a similar question in laboratory settings and from a more dog-centric perspective, observing canine behaviour during owner presence, brief separation, and reunion (Image 1). As we begin data analysis, I believe our findings will be valuable to shelter staff, trainers, and other professionals.

Another important outcome of my work with the AWP has been gaining a broader understanding of cross-country differences regarding social and systemic factors affecting pet ownership. Visiting Vancouver for the first time, I was surprised by the general ban on bringing dogs into many public spaces, such as restaurants, coffee shops, and more significantly, restrictions on taking dogs on public transportation, allowing travel only with small dogs. In Poland, such restrictions are minimal—all dogs are allowed on public transport (muzzled and leashed or in a carrier), and more and more restaurants serve dog dishes!

I was also interested to learn about the large amount of research in North America analyzing reasons for relinquishment or surrender of companion animals to shelters. For example, affordable pet-friendly housing seems to be a major concern for Canadian pet owners—something that would rarely arise in Poland, where non-pet-friendly buildings are almost nonexistent. In Poland, animal shelters are not legally required to accept animals surrendered by their owners, as they are intended to house homeless animals or those removed from homes due to abuse or neglect. While there is no data on the broader impact of this Polish regulation, an obvious consequence is the fact that shelter staff in Poland often lack detailed background information about the animals brought into shelter care.

PHOTO SUPPLIED BY JULIA MILLER

Equally surprising was the number of crossbreeds in British Columbia, including Labradoodles, Goldendoodles, and a wide variety of other poodle mixes. Under Polish law, such crossbreeds are classified as mixed-breed dogs and breeding them for profit is prohibited. This regulation is a part of the Polish Animal Protection Act, which is intended, among other things, to reduce the population of homeless dogs in Poland. However, the effectiveness of these strategies remains debatable, especially given that the number of dogs in official shelters alone hovers around 90,000, not including those cared for by independent animal rescue organizations.

My collaboration with the AWP has been a transformative experience, bridging my veterinary background and passion for animal behaviour with rigorous, applied research. Living in Vancouver for several months over the past three years deepened my understanding of the social and systemic factors influencing pet ownership across different cultural contexts and has sharpened my awareness of how policy, environment, and community practices shape companion animal welfare.

My partnership with the AWP continues, and we are now writing a joint application to further investigate the human-animal bond. I hope to return in 2026 to continue contributing to—and learning from—the HAI Lab team.

Note: The UBC Animal Welfare Program (AWP) collaborates with researchers and institutions worldwide. Over the past three years, Dr. Julia Miller, Assistant Professor and veterinarian from Wrocław University of Environmental and Life Sciences in Poland has been collaborating with the AWP to study dog behaviour.

For more information, visit awp.landfood.ubc.ca or the HAI Lab on Instagram @ubc_hai.

Reference: Miller, J., Cavalli, C., Azadian, A., & Protopopova, A. (2025). Exploring the impact of a brief positive experience on dogs' performance and stress resilience during a learning task. *PLoS One, 20*(6), e0326368. WCV

West Coast Veterinarian's "A Year in the Life" is a four-part column written by one veterinary specialist about one topic that has four distinct life phases. Through the course of the year, each instalment highlights how this topic affect animals at a certain life stage and what veterinarians should know about how to treat it. This year's focus is canine internal medicine.

INTERNAL MEDICINE IN THE ADULT CANINE

BY AMANDA BOOTH, BSc, DVM, MVSc, ACVIM (LAIM)

Dr. Booth's practice focuses only on small animals.

"Blaze" is an eight-year-old Bernese Mountain Dog. She belongs to a staff member, so of course she will have multiple challenges—Murphy's Law. My staff member adopted Blaze when she was a puppy because she had been too boisterous for the elderly owner. She has been a lovely girl.

Three years ago, Blaze had a left hind cruciate injury and a successful tibial plateau levelling osteotomy (TPLO) with our local surgeon.

A little less than two years ago, she started showing mild lameness in her right hind leg. Pain was localized to the stifle, and though there was no drawer, radiographs showed effusion suggestive of a partial cruciate tear. She was referred to a local surgeon for TPLO. While she did have a partial tear confirmed at surgery, the surgeon also noticed that the synovial membrane did not appear entirely normal grossly. Therefore, he took a synovial biopsy during surgery.

Unfortunately (but fortunately for the early diagnosis), the histology came back confirming synovial histiocytic sarcoma. Staging was done with abdominal ultrasound, lymph node biopsies, and three-view chest radiographs, and there was no demonstrable metastasis. The decision was to amputate the leg and follow up with adjunctive chemotherapy.

The amputation was a little more challenging than normal, because the scar tissue secondary to the TPLO made the identification of vasculature and nerves less straightforward, but the procedure went well.

After consultation with the oncologists, it was decided to begin adjunctive chemotherapy with lomustine starting at 50 mg/m2 and after the 10-day CBC, which did not show untoward neutropenia, increasing to 70 mg/m2 by mouth every 21 days. Because we believed we were dealing only with microscopic disease or possible complete excision, the aim was to continue for six cycles (if excision had not been possible the aim would have been to continue the q3week lomustine long term), while monitoring for signs of bone marrow suppression or liver dysfunction, since those are the most immediate concerns with lomustine.

Blaze did very well with her oral chemotherapy. She had fairly minor gastrointestinal upsets. Her CBC on days 10 post-chemotherapy and pre-next-dose chemotherapy showed low normal to mildly reduced neutrophil counts as expected but did not require dose adjustment. Her ALP did increase mildly (from 64 U/L pre-chemotherapy to 192 U/L by the third lomustine dose) but we started her on Hepato Support and the numbers did not increase further through the remainder of the six chemotherapy cycles.

Blaze did very well over the following 18 months. She has had some mild issues with mobility on three legs but has had a great quality of life. There has been no metastatic recurrence of the sarcoma.

Three months ago, though she showed no symptoms, my staff member noticed enlarged submandibular lymph nodes while grooming Blaze. On physical examination, generalized peripheral lymphadenopathy was noted. Lymph node biopsy confirmed lymphoma, which was reported as moderate to high grade. General bloodwork was normal, except for a mild anemia (hematocrit 31).

The difficult decision was discussed, whether to proceed with chemotherapy in a dog who has already undergone one round with cancer and chemotherapy. The owner decided that she did not want to expose Blaze to the full CHOP-type lymphoma chemotherapy protocol, since it can be quite intensive and Blaze tends to get anxious in kennel situations, even on trazodone or gabapentin. We did investigate the possibility of Laverdia, but it currently only has conditional approval in the US and is not yet available in Canada.

Ultimately, we decided to proceed with single-agent doxorubicin at 25 mg/m2, aiming for five treatments, one every 21 days. Although results can vary, I have seen some lymphoma dogs achieve long remissions with this protocol, which is a lot less rigorous in terms of the number of treatments required. As I have often discussed with my cancer patients, it can be reasonable to see how the individual tolerates each dose, with the option to discontinue the chemotherapy if side effects are too great. I have had a few cases in which patients were only able to tolerate two or three doses yet experienced remissions as long or longer than those who reported for a full course of chemotherapy.

"THREE MONTHS AGO, THOUGH SHE SHOWED NO SYMPTOMS, MY STAFF MEMBER NOTICED ENLARGED SUBMANDIBULAR LYMPH NODES WHILE GROOMING BLAZE."

Blaze, before her retrobulbar abscess was drained.

PHOTO SUPPLIED BY AMANDA BOOTH

Blaze responded very well, with the lymph nodes returning to completely normal on palpation after the first doxorubicin dose. She had mild gastrointestinal upset after the first dose, in spite of IV Emavert administered at the time of chemotherapy and Cerenia continued afterward. Her CBC was normal except for the mild anemia and low normal white blood cell counts at day 10. Chemistry screen prior to the second dose of doxorubicin showed blood urea nitrogen (BUN) and creatinine at the high end of normal, but otherwise normal. After the second dose of doxorubicin, she did experience more severe gastrointestinal side effects. Her appetite was impacted more severely and for longer and there was some diarrhea, in spite of Cerenia, Bio-Sponge, FortiFlora, and a bland diet. However, it was decided to proceed with the third dose of doxorubicin with a plan to reduce the dose by 25 per cent.

A few days before the next scheduled chemotherapy, the owner noticed Blaze having mechanical difficulty eating, pain opening her mouth, and the right eye began

to protrude. The two main differentials were the possibility of lymphoma developing in the retrobulbar area, versus a retrobulbar abscess, possibly predisposed by immunosuppression from the chemotherapy. To evaluate the cause of the proptosed eye, the gold standard option of a CT scan of the area was discussed. However, at this stage, finances simply did not allow for a referral for advanced imaging. The eye became progressively more painful and protruding over 24 hours, and the decision was made to anesthetize to evaluate, but there was a discussion that after everything Blaze had endured to this point, unless we could definitively identify a problem that we knew we could remedy, we might choose not to recover her from anesthesia.

Once Blaze was anesthetized, there was a red welt visualized just caudal to the last molar on the right side. When this was incised, by far the most satisfying amount of purulent material I have ever seen from a retrobulbar abscess poured out. The tract was gently expanded by sliding curved blunt tipped forceps dorsally through the opening we had created behind the last molar. A very large amount of purulent discharge was drained, and the tract was gently flushed with sterile Lactated Ringer's solution.

The swelling behind the eye was immediately greatly reduced, and Blaze was recovered and started on amoxicillin/Clavulin. Her eye returned to normal positioning over four to five days, and her appetite and ability to chew returned over a similar time. Unfortunately, her vision was affected (presumably due to stretching of the optic nerve when the eye was severely proptosed), but intraocular pressure has been consistently normal at 18–21 mmHg.

Blaze's third chemotherapy dose was obviously postponed while we dealt with the abscess.

Then, with the retrobulbar abscess clinically resolved for three weeks, we booked to give the third doxorubicin dose. Unfortunately, the pre-chemotherapy bloodwork showed that Blaze's kidney parameters had progressed from high normal to a BUN of 19 and a creatinine of 210, with a USG of 1.018. Her peripheral lymph nodes still palpated normal. A discussion was had with the owner about the wisdom of risking escalating the possible developing renal disease (on top of the quite severe gastrointestinal side effects of the last chemotherapy dose) versus the potential benefit of prolonging remission from the lymphoma if we were able to complete the doxorubicin series.

Ultimately, the owner decided to forgo future chemotherapy doses and hope that Blaze will be one of the lucky ones who get a long remission with a shorter than ideal chemotherapy course. In the meantime, she is living her best life, and we are all quite certain that she is actually part cat, having already used up at least four lives.

Remember "Poppy" from the last issue? Her owners were able to save up for joint taps, which confirmed the diagnosis of immune-mediated polyarthritis. Poppy continues to do well clinically on treatment (refer to *West Coast Veterinarian* issue 59, "A Year in the Life" https://www.canadianveterinarians.net/media/uqqppb5u/wcv-magazine-summer2025.pdf). WCV

JAMES HERRIOT IS DEAD

BY JAMES RODGERS

It was late. I was slumped in a chair in the waiting room of an emergency veterinary practice on Vancouver Island with an injured cat from our shelter when the sliding doors whooshed open. In a nanosecond, the energy in the room shot from a two out of ten to an eight.

A woman rushed in with an injured dog and everyone—those of us in the waiting room as well as the clinic's reception staff—was quickly brought up to speed. The injured dog, Diogi (pronounced Dee-O-Gee) and his family live in a remote community. They had taken a bumpy boat ride and then drove for three hours to get there. Diogi had been run over by a car, his back end was lame, and pink foam was coming from his mouth.

The staff quickly proposed some care options for Diogi, then added the approximate costs.

Diogi's "mom" was visibly shocked. She shared that this was her first time at a veterinary practice. Ever. She had assumed that dogs and cats were also eligible for "medicare," Canada's publicly funded health care system. Someone sitting a few seats over from me mumbled, "Yeah right." They weren't buying her story. I was, but then again, I had heard accounts like this many times before.

Diogi's mom's second shock was the amount of the quote. Fair, especially considering that most folks in Canada are unaware of how expensive human health care is because we rarely see a bill. So, someone seeking veterinary care for the first time would lack a frame of reference.

Then it was my turn to be shocked. The staff nonchalantly added that if she didn't have the funds for Diogi's proposed care, her other option was to give him up by signing an SPCA surrender form. The SPCA would then pay for Diogi's care and rehome him to someone else, for an adoption fee, once he had recovered.

I shouldn't have been shocked—I had been on the staff's side of that conversation many times in my role as a cofounder of CARE Network, a non-profit animal "rescue" and shelter near Tofino, BC. Maybe it was that I didn't have any skin in this game. Or was it that there was so much raw emotion on display?

Later, as I drove my now-treated, injured feline charge back to our shelter in Tofino in the wee hours of the morning, I thought about Diogi's treacherous journey to access veterinary care and how, for many remote communities, the experience of inequitable access is rooted in and compounded by a historical legacy that the veterinary industry and animal welfare sector must address. As I pulled up to our shelter, two realities crystalized for me:

1. James Herriot is dead.
2. The veterinary industry and the animal welfare sector need to modernize and, like most older systems in Canada, they need to reckon with some truths and reconciliations related to the Indigenous folks and communities they impact, especially those in remote areas.

Like James Herriot, 24-hour-on-call, family-owned, rural practices that commonly offered discounted services to financially-challenged families are largely a thing of the past. For certain, individual veterinarians cannot be expected to shoulder the cost of other people's animals, but it seems to me that the future looks increasingly corporate, as large companies buy privately owned clinics to benefit their shareholders. Veterinary care is obviously a flourishing, for-profit industry.

Meanwhile, access to care is increasingly challenging for many people, especially when the demand for veterinary services increases and the availability of trained staff, like veterinarians, decreases, while costs soar in many cases.

For those living in rural and remote communities, additional complexities—such as geography—compound the challenges of responsible animal care. Most veterinary practices are in urban areas, which can be difficult to reach, both financially and logistically.

"...FOR MANY REMOTE COMMUNITIES, THE EXPERIENCE OF INEQUITABLE ACCESS IS ROOTED IN AND COMPOUNDED BY A HISTORICAL LEGACY THAT THE VETERINARY INDUSTRY AND ANIMAL WELFARE SECTOR MUST ADDRESS."

PHOTOS SUPPLIED BY JAMES RODGERS

“AND THEN THERE IS THE EMOTIONAL TRAUMA, ESPECIALLY FOR CHILDREN, OF SEEING AND HEARING THE SUFFERING OF ANIMALS THAT HAS, IN SOME CASES, BECOME NORMALIZED IN THEIR COMMUNITIES…”

This isn’t the end of the story; it’s potentially just the first chapter. Corporatization of veterinary care doesn’t mean that we can’t collectively envision and enact a future where equitable access to veterinary care and other animal services—especially those that were defined as essential when COVID-19 prompted the sector to prioritize services—is available to everyone, whether they live in an urban, rural, or remote location.

Historically, the for-profit veterinary industry, often in partnership with volunteer and philanthropy-backed animal rescue groups, has managed to keep up with under-resourced animal challenges in many areas. But times are changing.

From my perspective, it feels like there are simply more dogs and cats around these days and that the ratio of veterinary staff to demand for their services is off kilter. Animal rescues and shelters also seem to be struggling more than ever (to pay staff, keep volunteers, cover rising transportation costs, etc.), while securing foundation money and donations for dogs and cats has become much harder.

My busy animal shelter operation near Tofino and the rural and remote communities we partner with along the west coast of Vancouver Island had already been feeling the squeeze of these pressures. And then COVID-19 happened, and it just about choked us out.

As a small, volunteer-based organization, we’re under-resourced in all the usual ways. Therefore, our modus operandi is to quickly transfer most dogs and cats that come to us for rehoming to urban animal shelters for adoption. This allows us to steadily remove the unwanted and socially challenged dogs and cats from the predominantly Indigenous communities we partner with when they request these services.

During the pandemic, however, this flow of unwanted animals to new homes became bottlenecked. The urban animal shelters that we work with couldn’t access veterinary services in a timely fashion, which stalled adoptions, causing the shelters to overflow and consequently pause their intakes. This meant that our rudimentary facility near Tofino also got backed up with too many dogs and cats, and we were no longer able to admit unwanted or dangerous dogs and cats from our partner communities.

Unwanted dogs in rural and remote communities are often young, unaltered (not spayed or neutered), and under-socialized. In many communities, these dogs roam freely. We often receive reports of dogs packing up and fighting (especially when there is a female in heat), jumping up on people for food or attention (sometimes knocking them over and causing injuries), and biting.

According to one statistic, did you know that the most likely person to be bitten by a dog in Canada is a 5–9-year-old in a rural Indigenous community? The stat goes on: they will probably be bitten on the face, on a Saturday, in the summer, between 4:00 pm and 8:00 pm, by a dog they are not interacting with.

And then there is the emotional trauma, especially for children, of seeing and hearing the suffering of animals that has, in some cases, become normalized in their communities (dogs in heat brutalized by other dogs, animals with untreated wounds, animals dying from viruses or untreated infections, etc.).

To make matters worse, unwanted litters of puppies and kittens, especially when in poor health, attract bears, wolves, cougars, and other predators into communities and increase the risk of human-wildlife conflict, which is dangerous for everyone involved.

Suffice to say, when the bottleneck problem hit, we felt mounting pressure to come up with a solution. I firmly believe that necessity is the mother of most, if not all, invention, and we needed the mother of all solutions. So, we went to a pub with a commitment to stay as long as it took to come up with our big solution. We landed on starting British Columbia’s first non-profit mobile veterinary practice, just halfway through our first pint. Phew!

We named the clinic Mission Pawsible (www.missionpawsiblevetclinic.com) because everyone said that our plan—get it started within four months for tens (not hundreds) of thousands of dollars—was impossible. It took us about five months, thanks in large part to the amazing folks at the CVBC.

As soon as Mission Pawsible was ready to roll, we drove our vetmobile and newly hired veterinary team to our backlogged urban animal rescue and shelter partners to get them caught up on spay and neuter surgeries, which allowed them to resume regular animal intakes from our West Coast shelter. This meant that we could once again open our doors to our Indigenous community partners and take in their unwanted and dangerous animals.

Mixed into our veterinary team’s more-than-full-time schedule were invited trips to chronically-underserved remote Indigenous communities around Vancouver Island to do spay and neuter clinics. The goal was to get their dog and cat populations under control and potentially slow the flow of unwanted animals ending up in shelters (and, subsequently, at the still oversubscribed veterinary practices).

These community visits typically include meeting with community leaders, administrators, and residents of all ages to discuss animal management going forward, including where animal bylaw enforcement might fit in, and so on.

In the community meetings, and more often while chatting with folks who don’t live in these underserved communities, I hear statements like, *“Dog and cat ownership should just be banned if people can’t look after them properly,”* and variations on questions like, *“Why do they get dogs and cats if there aren’t services (like veterinary care) available in their area?”*

There are several answers to these types of questions, but I find that they all sink in better when preceded by the historical context of how we got here (“here” being what, to many people, looks like Indigenous communities overwhelmed with under-socialized, unwanted, and uncared for dogs and cats).

First off, dogs have been members of many North American Indigenous communities for about 10,000 years. Shocker/not a shocker: those first dogs were largely wiped out soon after European settlers arrived.

Second, in Canada, the roots of the dog challenges in Indigenous communities go back to the 17th century when Catholic missionaries laid the groundwork for what would become the Canadian reserve system. Upon Confederacy, that system was centralized under the 1876 Indian Act, which aimed to control Indigenous communities and resources, while limiting their rights and autonomy. This included forcing communities to relocate to isolated pieces of land where government policies could be more easily applied and monitored.

Consequently, most reserves (3,174 of 3,394) are located away from urban centers, and thus away from the services and resources that only urbanity can provide, thanks to economies of scale. Therefore, in part by government design, folks seeking veterinary care in these Indigenous communities face financial and logistical challenges far greater than those living in or near urban centres.

In the 1876 Indian Act, the colonizing Government of Canada left the role of pound-keeper and the establishment of pounds for animal control up to the chiefs of bands and subject to confirmation by the Governor in Council. For the last 149 years, Canada has done next to nothing to support these obligations, nor has it provided the services (veterinary care) or infrastructure (spaces to safely shelter animals in need) required to keep communities safe from animal-related safety risks.

Oh yeah, and Canada has a fiduciary duty to First Nations that includes the responsibility to keep their communities safe, which is rooted in the Crown’s legal obligation to act in a fiduciary capacity, which includes protecting Aboriginal Peoples’ interests and welfare. So, heads-up to the Right Honourable Mark Carney: a back-dated bill may be coming in the mail soon for those 149 years of undelivered services and infrastructure.

Another impact of colonization on the current state of animal and community wellness traces back to the 19th-century establishment of the first SPCAs, humane societies, and other animal-helping groups in Canada. Historically, these organizations and teams have typically consisted of folks from Canada’s dominant culture. Even today, 84 per cent of people working in the animal

welfare sector identify as white and female with a middle-class background. When this type of work to "save" animals intersects with marginalized cultures, like Indigenous cultures, elements of a "white saviour complex" can arise, often unintentionally and implicitly. This can show up as a feeling or assumption that marginalized people need outsiders to solve their problems, that they are fundamentally incapable of doing it themselves, which implies that the outsiders are in some way superior.

So, after sharing how colonization has been a major contributor to the current state of animal and community wellness and safety with those folks who ask, *"Why do they get dogs and cats if there aren't animal services (like veterinary care) in their area?"* I respond with information about One Health and the interconnectedness of animal and human health and safety. This includes how dogs and cats can be essential to people's emotional well-being and mental health as well as all the interrelated safety concerns.

People who live in communities that lack access to animal services have the right to have dogs and cats as part of their families, so long as they have the intention of providing the animals with their five freedoms—freedom from hunger and thirst; freedom from discomfort; freedom from pain, injury, and disease; freedom to express behaviours that promote well-being; and freedom from distress. And it is up to all of us to do what we can to ensure that everybody has access to the resources and services they need to do that.

To this end, one thing you can do is support the work of Increased ACCESS (Animal Care & Community Empowered Safety Society www.IncreasedACCESS.org), an Indigenous-led non-profit federal charity. Increased ACCESS works with their Indigenous nation-members to increase access to animal services like veterinary care, animal management planning, and animal bylaw development and enforcement. Increased ACCESS is also working to enact a decolonized future for the animal welfare sector.

Some milestones along the road to this decolonized future will include:

- More Indigenous perspectives and voices integrated into federal and provincial decision-making processes regarding policy and funding that impact animal-related Indigenous community health and safety.
- Annual, predictable federal funding so that delivery of the essential animal services that impact Indigenous community safety is no longer dependent on hit-and-miss volunteerism and philanthropy.
- Support for the seeding of the non-profit veterinary sector across Canada.
- Dogs and cats moved from the oversight of provincial ministries of agriculture to the care of provincial ministries of health, as a step towards realizing One Health.
- Development of a non-paternalistic, non-colonial SPCA (see www.IndigenousSPCA.com) with Indigenous knowledge integrated into solutions.
- Affordable animal infrastructure for rural and remote communities.

Mission Pawsible, the non-profit mobile veterinary practice we started a few years ago is proud to be an ally of Increased ACCESS. Together, we are working towards enacting a decolonized and just animal welfare sector rooted in the principles of One Health, so that dogs like Diogi can live long, healthy lives with their families, no matter where they are located.

James Herriot may be dead but the non-profit veterinary sector is alive and growing up fast. Mission Pawsible has already developed four vetmobiles, each for well under $100,000, thanks in part to many traditional veterinary practices that donated their broken autoclaves, unwanted anesthetic machines, and extra patient monitors, among other items.

A big thank you must also go to our veterinary teams who persevered through a unique and stressful start-up process and, in just one year, did more than 1,000 spays and neuters in an 18-foot enclosed trailer. A special thanks goes out to Bill, our rocket-building, dog-loving, mechanical genius.

Next steps for Mission Pawsible include advocating for our "pet project," getting veterinarians and RVTs added to StudentAidBC's student loan forgiveness program with an emphasis on new grads joining the non-profit sector (paid at market rates), and establishing a base of operations in the Fraser Valley so we can better help underserved communities throughout mainland BC. At present, our biggest limitation is securing funding for our non-profit spay and neuter surgeries for those who need them most.

To support efforts to get essential veterinary services to chronically underserved communities, consider a financial donation (www.missionpawsiblevetclinic.com), donating old or broken autoclaves or other equipment (info@missionpawsiblevetclinic.com), or joining our team as a volunteer or employee (info@missionpawsiblevetclinic.com). WCV

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Dr. Fernanda Mantovani

Dr. Fernanda Mantovani earned her veterinary degree from São Paulo State University in Brazil, followed by clinical rotations at the University of Wisconsin-Madison, where she was inspired to pursue a specialization in medical oncology.

After receiving her American Veterinary Medical Association certification in 2009, she completed a rotating internship in medicine and surgery at the University of Missouri. She then undertook an oncology specialty internship and residency, along with a Doctor of Veterinary Science (DVSc) program at the Ontario Veterinary College. In 2016, Dr. Mantovani became board-certified by the American College of Veterinary Internal Medicine.

Dr. Mantovani spent a decade practicing medical oncology in the Greater Toronto Area, where she led a busy downtown service and helped establish an oncology department at a new hospital. Drawn to the West Coast lifestyle and climate, she joined the Vancouver team in 2025, bringing her extensive clinical expertise and passion for collaborative, patient-centered care.

Her favourite part of oncology? The strong relationships built with clients and the teamwork across specialties that helps deliver the best possible care for pets.

ACUTE KIDNEY INJURY AND CHRONIC KIDNEY DISEASE *IN CATS AND DOGS*

BY EWAN WOLFF, PhD, DVM, DACVIM (SAIM)

Kidneys are built on redundancy. They can manipulate their environment to provide more oxygen, adjust blood flow and pressure, process acids and bases, adjust electrolytes, absorb and secrete a variety of products including water, interact with calcium homeostasis, and perform a host of other functions. There are around 200,000 nephrons in cats and just shy of 500,000 in dogs to spread out all this work. For all those reasons, it can take a long time to figure out that something is wrong.

PHOTOS SUPPLIED BY EWAN WOLFF

IRIS GUIDELINES

The International Renal Interest Society (IRIS) guidelines depart from "normal" reference lab ranges to identify more subtle trends in acute kidney injury (AKI) and chronic kidney disease (CKD). IRIS AKI grading has been continuously upgraded with the evolution of human scoring systems and is currently based on Kidney Disease: Improving Global Outcomes (KDIGO) classification. IRIS CKD staging has been upgraded within the past decade to include symmetric dimethylarginines (SDMA) to detect early changes in renal function. In a hydrated patient, a 26.53 umol/L shift in creatinine is consistent with AKI even within the normal range. Staging of CKD patients, whether in cats or dogs, may be based on trends when the creatinine is consistent with early stages and is substaged for proteinuria and hypertension. Despite a longstanding history of IRIS grading and staging being available, AKI and CKD are routinely missed in lab work. This can not only slow clinical responses but also dull sensitivity to primary renal conditions (e.g., pyelonephritis, ureteral obstruction) and systemic conditions (e.g., pancreatitis, endocrine diseases) that have secondary effects. Simply incorporating IRIS classification into evaluation-of-patient lab work will sharpen recognition of renal dysfunction.

ACUTE KIDNEY INJURY

AKI is likely happening all the time given our low clinical awareness around small shifts in creatinine. Whereas a creatinine of 230 umol/L might be considered a mild acute increase by some veterinarians, it is the beginning of IRIS AKI Grade III (out of V) and a threshold for considering dialysis in humans. Although values like this may improve with therapeutic intervention (or patient healing), many patients then go on to develop CKD. Heightened vigilance may reduce the long-term impact of a single AKI event.

Common AKI causes in cats include lily toxicity, nonsteroidal anti-inflammatory drug (NSAID) toxicity, ureteral obstruction, urethral obstruction, and pyelonephritis. Clinical history is essential, including toxin exposure, medications, lifestyle, housing, number of litter boxes, and travel. Comparison of past and current physical exam data (e.g., cardiac health, muscle mass, weights) and clinical data (e.g., blood pressure, bloodwork, urinalysis, urine protein creatinine measurements, urine cultures, imaging) are key to interpretation of current clinical status. Initial evaluation of patients with AKI should first include PCV/TP (to determine if the patient is too anemic to sample extensively), followed by CBC, chemistry, urinalysis with reflex UPC, urine culture where indicated, total T4, blood pressure, and renal point of care ultrasound. If renal values are severely elevated with no appreciable clinical signs, then FeLV/FIV screening and kidney aspirates (in a specialty setting) may be added. Significant renal pelvic dilation on ultrasound (e.g., > 0.35 cm) should prompt discussion of potential obstruction and referral. The presence of significant dilation and a negative culture should prompt fluoroquinolone antibiotic therapy if clinical signs suggest pyelonephritis.

Treatment for AKI in cats starts with three key elements: (1) prompt recognition of potential ureteral obstruction with referral for subcutaneous ureteral bypass (SUB) system placement if indicated, (2) prompt recognition of urethral obstruction and relief, and (3) avoiding fluid overload. It can be easy to mistake dry mucous membranes from uremia for dehydration and put these patients on very high fluid replacement rates. Evaluation of hydration incorporates a constellation of historic and current data including weight, hemoconcentration, sodium level, protein, USG, caudal vena cava measurements, and skin turgor.

The treatment plan is based on the treatable abnormalities, such as high blood pressure, anemia, hyperkalemia, and other electrolyte derangements (namely, hyponatremia and hypernatremia), many of which may correct with crystalloid therapy, although sodium requires special attention—while hyperkalemia is a serious and potentially fatal complication, KCl supplementation for hypokalemia is straightforward as opposed to fluid therapy for sodium derangements. Patients may have severe anemia (< 20 per cent and clinical) that requires transfusion and at least one darbepoetin dose to start to correct. Non-regenerative anemia can be present with either CKD or AKI and is a common finding in veterinary dialysis units. Although our understanding of AKI remains in its infancy, even in human medicine, researchers hypothesize that AKI-related damage to the renal parenchyma impairs erythropoietin production, resulting in anemia. Hyperphosphatemia may correct on its own during initial therapy, and phosphate binders should not be given until a patient is capable of eating. Early nutrition intervention with well-balanced diets (not focused on renal diets) is also important. Patients taking ACE inhibitors or ARBs should have these medications discontinued as it may provide a 10–20 per cent improvement in GFR. Once hydrated, chloride in the fluid prescription should be lowered to reduce tubuloglomerular feedback and enteral water emphasized. Recheck lab work should be considered at several days, 2 weeks, 1–1.5 months, and 3–4 months to track recovery from AKI and the development of CKD.

> “CKD IS TO SOME EXTENT MULTIPLE PROCESSES THAT INVOLVE INFLAMMATION AND SLOW DEGENERATIVE DAMAGE WITH NEPHRON DROPOUT.”

Common causes of AKI in dogs include grape/raisin ingestion, antifreeze toxicity, NSAID toxicity, leptospirosis, pyelonephritis, and AKI secondary to pancreatitis. Research findings suggest pancreatitis may cause secondary AKI via hypovolemia, cytokine-induced ischemia, inflammation, and oxidative stress. Much of the same clinical history, physical exam, and diagnostic testing apply as in cats. Additional considerations are IgM leptospirosis testing and urine PCR, free T4/TSH where relevant, baseline cortisol, ethylene glycol testing, Spec cPL/PL/DGGR or PSL, and urinary cystatin B (in the context of other evidence).

Treatment in dogs is similar to cats, with a few considerations. Ingestion of medication and other toxins is common in dogs and recommendations frequently involve high fluid rates. If a patient is euhydrated, these high fluid rates will not increase GFR, may cause irreparable harm from fluid overload, and are no longer recommended. For leptospirosis and other susceptible infectious diseases, early treatment with doxycycline helps reduce ongoing damage. Attention to hastening the improvement of pancreatitis is key to recovery of secondary AKI cases.

CHRONIC KIDNEY DISEASE

CKD is to some extent multiple processes that involve inflammation and slow degenerative damage with nephron dropout. A subset of individuals’ CKD may be the sum of episodes of AKI. This might explain occasional inconsistency of progression in creatinine values. One of the great curiosities of CKD is that creatinine values on paper do not necessarily translate to severity of clinical signs. The constellation of sequelae that can occur from kidney dysfunction are not uniform.

Proteinuria and hypertension are a part of IRIS substaging, and ongoing evaluation and treatment are essential. Electrolyte abnormalities such as hypo and hyperkalemia, hypo and hypercalcemia, hyperphosphatemia, hypo and hypernatremia, and hyperchloremia can occur as a result of CKD or as a secondary disorder to systemic diseases that promote CKD. Non-regenerative anemia can progress to the point of organ damage so slowly that patients remain stable and unaware. Clinical treatment of CKD involves advanced detection of progression, dietary and supplement changes where relevant, and medical therapy of side effects.

Cats often have occult signs during early CKD (even seemingly when they’ve had a ureteral obstruction in one kidney). Full recent lab work, including CBC, chemistry, urinalysis, and total T4 is recommended. It’s not uncommon to review records and find subtle decreases in USG and slow creatinine rises that long preceded clinical signs. Additionally, chronic renal cortical changes may be noted incidentally on ultrasound for other conditions even in younger patients. Besides SDMA, there is a new feline FGF-23 test that can direct early phosphate dietary restriction and slow progression to renal secondary hyperparathyroidism. There is also improved access to point of care total T4, urine/protein creatinine ratio reflex add-ons, urine culture and sensitivity, and point of care ultrasound that aid ongoing monitoring.

Common treatments for cats include dietary intervention with canned mildly-reduced protein diets in IRIS Stage I and early-Stage II CKD (provided there are no uroliths) and moderate protein restriction in mid-Stage II to early-to-mid-Stage III CKD. Early CKD patients may benefit from omega-3 and omega-6 fatty acids for long term anti-inflammatory effects. Hypertension management benefits from amlodipine in higher level hypertension and enalapril/telmisartan in patients where a 10–20 per cent reduction in blood pressure would drop the pressure below 150 mmHg. Proteinuria is treated with enalapril/telmisartan to a 50 per cent reduction in UPC or < 1.0 in patients where a 10–20 per cent increase in azotemia would not lead to clinical deterioration. Although immune-mediated and familial nephropathies are not as common in cats, some patients with proteinuria may require immunosuppressive therapy. Hypokalemia is common in advanced CKD and potassium gluconate is commonly supplemented. Hypocalcemia can occur as a result of decreased vitamin D synthesis and can be treated with calcitriol supplementation. Hyperphosphatemia can be treated with phosphate binders, although aluminum hydroxide has the potential to be nephrotoxic. Products like Epakitin and sevelamer can be used for phosphate binding with caution for severe azotemia. Anemia below 25 per cent has traditionally been treated with darbepoetin, but a new feline HIF-PH inhibitor exists on the US market that interferes with the root cause of low epoetin. Additional tools include lactulose for constipation to help reduce azotemia and a feline carbon-based absorber supplement that helps bind uremic toxins but does not reduce azotemia. Consistent subcutaneous fluid therapy is more limited to palliative care of advanced stage CKD than earlier intervention due to the chloride content of crystalloids.

In dogs, familial nephropathy and autoimmune glomerulonephropathies are prevalent (whether primary or secondary to prior infectious disease exposure), so attention to proteinuria with UPCs is important. In these cases, early planning for follow up urine protein electrophoresis +/- kidney biopsies in cases that are resistant to ACE inhibitors and ARBs is recommended. This testing is to determine if patients would benefit from immunosuppressive therapy with mycophenolate. Additionally, pancreatitis with secondary AKI can be repetitive and drive CKD forward in dogs. Dogs are more often also chronically on NSAIDs for osteoarthritis and soft tissue injury, which can cause a slow and steady creep in creatinine. Otherwise, diagnostics are fairly similar to cats, with the exception of more emphasis on pancreatic tests and ruling out hypothyroidism and hypoadrenocorticism as contributors to azotemia. Full lab work, urinalysis, blood pressure, and abdominal ultrasound are essential.

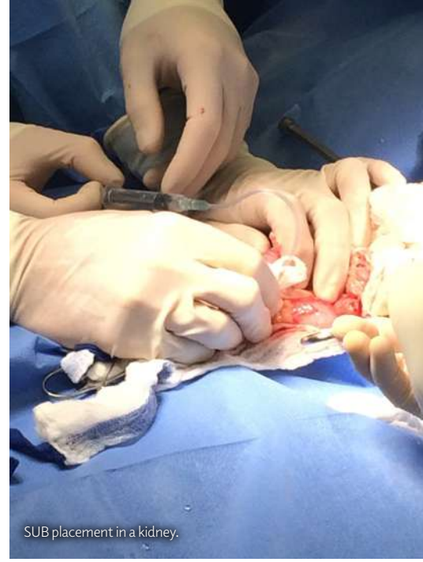
Much of treatment of CKD in dogs mirrors interventions in cats, with some notable exceptions:

- Due to a high level of activity in some dogs, mild (rather than moderate) protein restriction with early-IRIS Stage II CKD is important to maintain muscle mass.
- Patients with juvenile renal dysplasia may have severe azotemia at a young age but no clinical signs. These patients should not be severely protein restricted as they may live years without clinical signs and require muscle mass for quality of life.
- Teacup and toy breed dogs have extremely low muscle mass. Baseline creatinine falls well below the normal range, and lab ranges and IRIS staging can miss severe progression of azotemia. Monitoring proportional shifts in creatinine and severity of clinical signs in these patients is critical to treatment.
- There may be a proportionally higher number of cardiorenal dogs receiving diuretics for congestive heart failure. This can lead to significant clinical challenges around water supplementation, limitation of ACE inhibitor use, dietary choices, and diuretic prescriptions.
- Dogs with progressive CKD may have more significant clinical signs earlier in the course of their disease. Symptomatic care may be more extensive at lower IRIS staging.
- From my perspective, early intervention with bouts of acute or acute on chronic pancreatitis may help slow the cycle of cumulative progression of CKD in some patients.
- For both dogs and cats, antimicrobial stewardship around subclinical bacteriuria is required to prevent multidrug-resistant infections. These infections can lead to ongoing recurrent or non-resolving clinical pyelonephritis that can drive progressive azotemia.
- In my opinion, attention to underlying causes of urinary incontinence and urine retention in older patients can be a tool in slowing the progression of CKD by helping to avoid recurring ascending infection. The same can be said of working to improve chronic diarrhea that can be a prompt for repeated urinary tract infection.

There is no miracle cure for kidney damage. Stem cell therapy has not panned out to be a widely available or effective treatment for CKD. Feline kidney transplant outcomes were not good enough to justify the cost, wait times, and personal impact for most clients. There is no monoclonal antibody therapy (yet) for CKD. Dialysis is an effective therapy for some AKI patients and may help CKD patients for a constrained period of time but the kidneys must heal themselves. Even fluid therapy doesn’t increase glomerular filtration rate in hydrated patients and may cause fluid overload and death. We have to do better at recognizing patterns on the front end to save as much function as possible. We also need perspective on outcome of care in these patients.

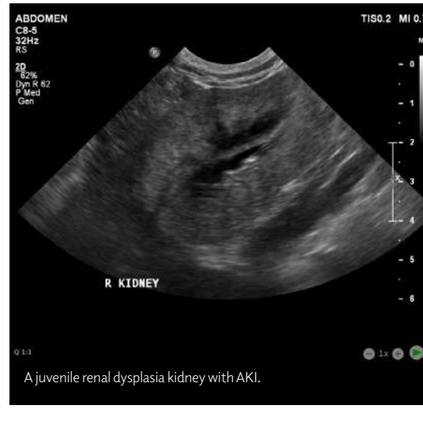
Quality of life, especially when we are introducing food that may be less palatable to patients and extensive drug regimens, should be a prime consideration. I try to see therapy of all kidney diseases in dogs and cats as a short, medium, and long-term plan. Lab value improvement should never override quality of life. Sometimes it’s ok to accept some mild progression if that time is symptom free. It all comes down to having a collaborative treatment plan and outlook with our patients’ families.

To save space, the references for this article are made available on the Chapter’s website at www.canadianveterinarians.net/sbcv/west-coast-veterinarian-magazine. WCV



SUB placement in a kidney.

A dog on dialysis for AKI.



A juvenile renal dysplasia kidney with AKI.

EARLY DETECTION AND ASSESSING THE RISK OF **MSI IN THE VETERINARY SECTOR**

BY STEPHANIE SWAIN

From June 26 to 28, AgSafe proudly hosted a booth at the CVMA Convention in Victoria. In conversations with veterinarians, animal health technologists, and veterinary technicians, one thing was clear: the well-being of animals is always top of mind for those of you who care for them. As a pet owner who is deeply rooted in the agriculture industry, I want to thank you for the vital work you do every day. While your focus is on your patients, I encourage you to remember that your own health and safety matter just as much.

MUSCULOSKELETAL INJURIES IN BC'S VETERINARY SECTOR

Veterinary work can be physically demanding. Tasks such as lifting, reaching, and repeating the same motions can place strain on the body, particularly the neck, shoulders, arms, wrists, legs, and back. These injuries, which affect muscles, tendons, ligaments, joints, nerves, and blood vessels, are known as musculoskeletal injuries (MSIs). According to WorkSafeBC data from 2018 to 2023, MSIs accounted for approximately 19 per cent of all injury claims in the veterinary sector.

SIGNS, SYMPTOMS, AND EFFECTS OF MSI

Some of the observed signs of MSI include redness, swelling, and limited movement. Symptoms of MSI can include pain, numbness or tingling, sore or stiff muscles and joints, weakness, and tenderness.

If not treated, MSIs can progress into long-term conditions such as sprains, strains, tendinitis, and carpal tunnel syndrome. The early stages of MSI are often painful, but in a late stage, the injury can be disabling, affecting sleep and interfering with tasks at work, at home, and in recreational activities.

Know where and how to report signs and symptoms of MSI and seek treatment to prevent the injury from getting worse. The earlier you detect and report the development of an injury, the better your chance is for recovering quickly.

"AGSAFE'S CERTIFICATE OF RECOGNITION (COR) PROGRAM ENCOURAGES WORKPLACES TO ASSESS RISKS BEFORE INJURIES HAPPEN."

MSI RISK ASSESSMENT

An MSI Risk Assessment identifies tasks that may pose a risk and determines ways to minimize that risk. Employers should first prioritize high-risk tasks by reviewing workplace injury records—such as first aid reports and claims histories—for signs of recurring MSIs. When addressing these risks, applying a hierarchy of controls (Figure 1) helps ensure that the most effective solutions are considered first.

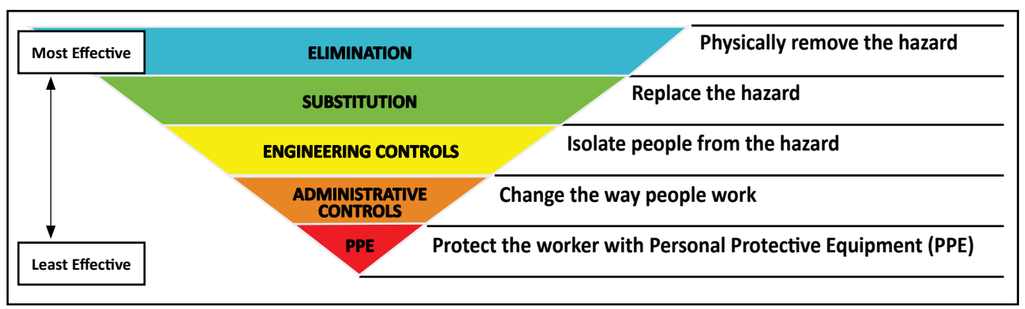


FIGURE 1: The hierarchy of controls ("Controlling Risks," WorkSafeBC www.worksafebc.com/en/health-safety/create-manage/managing-risk/controlling-risks).

COURTESY OF MIDMARK CORPORATION / THE STEVENS COMPANY LTD.

PHOTOS 1–3: A mobile life table.

According to WorkSafeBC data (2018–2023), 13.4 per cent of all reported injuries in the veterinary field were due to back strain. The example of an MSI Risk Assessment for the task of moving animals onto an examination table illustrates how workplace risks are identified and mitigated using the hierarchy of controls (Table 1).

TASK	MSI RISK FACTOR	CONTROL	
Moving an animal to the examination or operating table.	Lifting, lowering, carrying.		Utilize mechanical lift aids or mechanical lift table.
			Establish safe lifting work procedures and ensure workers are trained.
			Examine and redesign the workplace layout.

TABLE 1: Using the hierarchy of controls to address back strain from lifting animals.

While moving animals to the table poses a hazard that cannot be eliminated or substituted, engineering controls, such as mechanical lift aids, are the next best option. Administrative controls, such as safe work procedures and examining the workplace layout, may also be options to reduce the risk of injury.

AgSafe's Certificate of Recognition (COR) program encourages workplaces to assess risks before injuries happen. COR is a formal acknowledgment of health and safety management systems that meet industry standards. For more information about AgSafe, visit www.AgSafeBC.ca. WCV

Stephanie Swain is the Certificate of Recognition (COR) Program Manager at AgSafe BC. She grew up in the Fraser Valley being surrounded by the diverse agriculture of the area. Stephanie has a background in Marketing and Hospitality Management from Douglas College, which led her to Conference Service Management. Over the years, she coordinated numerous health and safety conferences and events which made her familiar with various associations like AgSafe BC. In 2015, Stephanie joined the team at AgSafe BC as the COR Program Administrator. While maintaining and helping to develop the COR Program, she has really enjoyed the interaction with all the different sectors of the agricultural industry and learns something new each day related to health and safety.

The following individuals were the two funded BC delegates for this year's CVMA Emerging Leaders Program, selected from the largest applicant pool in our history, with 23 applications received.

CVMA EMERGING LEADERS 2025

BY MARY VON DER PORTEN, BSc, MRM, DVM

Anyone reading this magazine knows that the veterinary industry can be mentally taxing, and finding purpose and meaning in the profession while keeping our heads above water is a challenge. Connecting with our passions within this work, however, is a key element in career satisfaction. I enthusiastically joined this year's emerging leaders program to become an effective leader in the environmental sustainability of the veterinary industry. I wish to pursue my passion while continuing to be a general practitioner in a rural area, take on challenging cases and surgeries, mentor new grads, and have a healthy and balanced life. Simple, right?

The hours we spent with our instructor, Rob Marr, were fascinating and felt like exercising a muscle I'd never known existed. I now know that leadership must be learned and that it's not an inherent part of being a DVM (seems obvious now, but when a dog is coding and you're directing a team, you may be under the illusion that you have leadership skills). We began with a personal commitment to be in the growth mindset at work with a clear vision of what we need to change in our day to day to achieve it. This necessitated personal reflection and left us looking back on what broke us at work, such as personal conflict.

My first lesson: We need to lead by example in our conduct with others.

There was a session on personal awareness, examining the tasks we do each day and seeing if we can allocate those to others. We talked about how hard change is to overcome for all of us and that we are hardwired to resist change. Status quo is more comfortable.

My second lesson: We have inherent negative biases we must address when initiating anything new in the workplace.

"THE CRINGEWORTHY YET PROFOUNDLY HELPFUL CORE OF THE SESSION WAS THE PERSONALITY TEST."

The cringeworthy yet profoundly helpful core of the session was the personality test. While we all look in the mirror in the morning, we don't always have to look in the personality mirror. Seeing our own personal scaffolds was eye opening. Being aware of who we are makes us better leaders because we can capitalize on our strengths and get support for our weaknesses.

My third lesson: Embrace your true self, don't fight her.

Finally, we finished the session with communication and key coaching tips. One helpful tip was to catch people when they are doing things correctly and say something to acknowledge them (sounds a lot like a parenting book). In addition, people support what they create, so any changes within the clinical setting must come from the staff themselves. Leaders develop culture within the workplace for a growth mindset. When guiding others, rather than *telling* them what to do, ask them a question like, "What are we trying to achieve here?"

My fourth lesson: Empower those around you and don't live under the illusion of control—then, and only then, will we be free of ourselves.

Once Rob's leadership framework was laid down, it was apparent that these fundamentals can be applied to many areas of practice and life. For me, this includes leadership in sustainability, while for others, it includes practice ownership, better management of staff scheduling, or working with university students. The variety of applications are as varied as the animals we see.

Take-home point: Leadership is difficult. Being a veterinarian is difficult. Be kind to yourselves.

Thank you to the CVMA for this opportunity and I hope that together we can make veterinary science and practice something that we are proud of for many generations to come. WCV

BY ASHLEE ALBRIGHT, BSc, DVM

After many years of wanting to take part in the CVMA's Emerging Leader Program (ELP), I was finally at the right place, both in my career and geographically, when the CVMA Convention returned to my hometown of Victoria, BC, this June. Like many of you, I have gone through several stages of my career. We all go through those first few tough years climbing that steep learning curve as we develop our technical skills and knowledge and learn how to communicate with people. Then we hit our stride, really honing the professional skills that we find fun and interesting while making time to build our personal lives—starting a family or fulfilling our passions outside of work. If we are lucky, this stage of contentment might last for quite some time or even until retirement and beyond! Unfortunately, I see how colleagues struggle with maintaining happiness and longevity in the workplace. The following hurdles are not new to any of us: burnout, client financial constraints, compassion fatigue, imposter syndrome, and interpersonal conflict. Although veterinary professionals are a skilled and intelligent bunch, we aren't exactly selected for the really important qualities that make naturally good leaders: emotional intelligence, resilience, collaboration, and self-awareness, to name a few. These soft skills need to be modelled, learned, and practiced over time until they become second nature.

In 2023, I opened a house-call euthanasia and palliative care practice (PenVet Mobile Veterinary Services) with my colleague, Dr. Mary McDowell. While PenVet was gaining traction in our community, we began developing Peninsula Veterinary Hospital the following year. We now operate both practices simultaneously and have grown our team exponentially. Building a startup hospital is exciting and fulfilling, but it comes with unique challenges like building a functional (and happy) team—from scratch! As a new practice owner, I wanted to better understand the softer skills that make a great leader. Navigating interpersonal conflicts, triaging, communicating, and delegating hospital priorities, and encouraging professional growth in my team have become more important than ever in my career.

One of the first points we learned from Rob Marr, the ELP's professional coach, is that the experience of working with different (and challenging) personalities is both normal and universal. Although we can't control other people, we can lead by example and actively work to keep our own behaviour "above the line," which means that we are accountable, we take ownership, and we are responsible for our behaviours. We learned that change is inherently hard because, as humans, we're hardwired to protect ourselves from risk. Resisting change is the first step in processing what is coming and will eventually lead to contemplation and planning for change. Asking someone to validate why the change should not happen opens up the conversation, decreases conflict, and reduces barriers to accepting the change.

Encouraging skills development within a team requires constant shifting between training, mentoring, and coaching. While training and mentorship are important to transfer knowledge and allow people to feel supported and confidently competent, coaching leads to engagement, professional growth, and offers the opportunity for people to fulfill their potential. Coaching encourages curiosity by asking neutral questions to facilitate thoughtful conversation. We learned several tangible coaching tools for handling conflict and giving feedback.

I hope to practice these concepts and tools as I navigate the challenges (and celebrations) of practice ownership during this next phase of my career. I know that we can be a healthier and happier profession and that together we can coach each other to new heights. I am very grateful to the CVMA, the SBCV, and Rob Marr for making this leadership workshop possible and accessible. WCV

"ALTHOUGH WE CAN'T CONTROL OTHER PEOPLE, WE CAN LEAD BY EXAMPLE AND ACTIVELY WORK TO KEEP OUR OWN BEHAVIOUR 'ABOVE THE LINE,'..."

ADVENTURES WITH EDDIE

BY ELAINE KLEMMENSEN, DVM, CEC

In the spring of 2022, a small brown ball of fur arrived in our lives and quickly reminded us of the exhaustion, frustration, responsibility, and intense, all-consuming love that comes with a new puppy. Three years earlier, we said a painful goodbye to our elderly terrier, Maisy. We were guilt-ridden and heartbroken as much of the last year of Maisy's life had been spent living with our friends while we travelled the world as volunteer vets. "No more pets," we vowed. Our love of travel and adventure just didn't fit with pet ownership. Then, in 2020, the world went into lockdown and with the arrival of COVID-19 came a surge in pet ownership. It seemed like everyone was adopting four-legged friends. We held firm, believing this virus would be a temporary blip in our itinerary of adventures. A year passed by in a fog of fear, uncertainty, and social distancing. Followed by another year, and then, just as travel was returning to our agenda, the longing began. I missed the unconditional love of a dog, and our home felt a little too empty without the click of nails across the floor and far too clean without the dust bunnies of fur hiding in the corners. I started scanning online listings and was shocked by the price tag attached to designer "mutts." I shared pictures of cute puppies with my partner, Rob, who remained adamant that our lifestyle did not support dog ownership. I reminded him of Zero, a small Chihuahua-Pug mix owned by one of our team members, who Rob had really liked. "Maybe a small dog like Zero could travel with us?" I suggested. He looked over at me and frowned, but this time there was no emphatic "no." Then, during a visit, our daughter, Hannah, looked up from her laptop and said, "You know what would be a perfect dog for you two? A Norfolk Terrier. They're small, sturdy, and affectionate. I bet you could train it to ride on a bike." Four months later, Eddie arrived, reminding us of the magic pets bring into our lives and forever changing the way we travel.

Eddie fell in love with cycling, and we fell in love with Eddie. His first adventure, a three-day bikepacking trip from Chute Lake to Midway, BC, was quickly followed by six weeks across Newfoundland. Bikepacking, a type of adventure travel that involves strapping gear to a bicycle instead of carrying it on your back, has exploded in popularity in recent years. The original bikepacking ethos of carrying only essential gear to remain light, nimble, and able to explore places less travelled is a bit at odds with adding a dog to your kit. Yet, we're clearly not alone in our desire to enjoy travel with our dog. Many readers, I'm sure, have followed the adventures of Mira and John—the first dogpacking duo to race the Tour Divide, which stretches from Banff to the US-Mexico border. We estimate that Eddie, along with his essentials (food, toy, first aid kit, riding basket, and collapsible airline kennel), adds 10 kg to our bikes. In addition to weight, bikepacking with a dog adds other logistical challenges and considerations (see DOGPACKING 101). Given the added challenges, why bother? Wouldn't it be easier to leave Eddie behind? Yes, and…

As I reflect on the adventures we have shared, I see they are intimately connected with resilience—the ability to bounce back from life's challenges. Dogpacking not only nurtures the bond I share with Eddie, but it has also strengthened the five interconnected elements in my personal recipe for well-being: a sense of purpose, time in nature, space for reflection, belonging and community, and awe.

SENSE OF PURPOSE

We often think a sense of purpose must be big or life-changing, like curing cancer or solving homelessness. But finding purpose can also be quite simple: something that has personal meaning and connects you with the world outside yourself. I am fully aware that travelling on a bicycle with a dog isn't significantly impacting the world. For me, the purpose lies both in the *doing*—setting and achieving a physical goal—and in the *being*—embracing the present moment. Slow travel by bike provides a counterbalance to our fast-paced, media-driven culture, helping me reconnect to my values of kindness, curiosity, courage and fun. It helps me find my way back to optimism and hope.

TIME IN NATURE

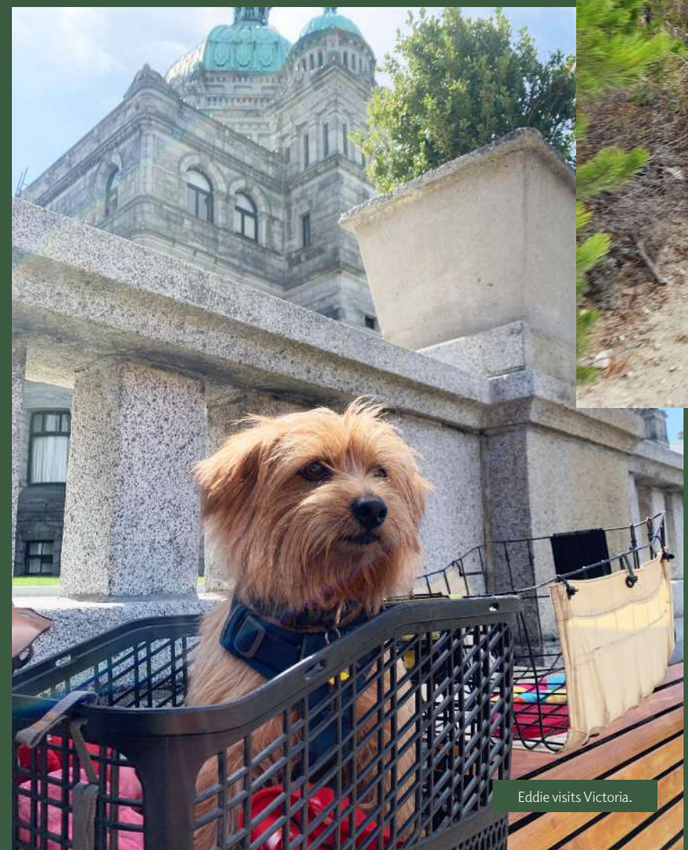
The restorative power of the natural world has long been known. Consider the words of naturalist John Burrows, written in 1921, "I go to nature to be soothed and healed, and have my senses put in order." More recently, a growing body of research in the field of ecopsychology shows that human health—physical, mental, and emotional—is intimately connected to the health of the Earth. Time outdoors connecting with the natural world isn't just nice to have; it's essential for our well-being. Bikepacking is just one way to disconnect from modern technology and life's stressors, allowing us to reconnect with the natural world. It's a perfect recipe to restore a frazzled nervous system and find a sense wholeness.

SPACE FOR REFLECTION

In a society that celebrates productivity and busyness, we sometimes fail to recognize the value of doing nothing. Neuroscience research has found that our brain toggles between two modes. Our executive mode, or task focus mode, is activated when we concentrate on external demands requiring higher cognitive functioning, like performing a complex surgery or solving a calculus equation. In contrast, our recharge mode, or the default mode network, activates when we are not engaged in a demanding, externally-oriented mental tasks. Think of those moments when our minds wander, like when we walk the dog and find ourselves contemplating a future vacation or what to make for dinner. Studies on performance show we don't need to do more to perform better; we need to do less. When

The bike setup.

First trip at four months old.



Eddie visits Victoria.

PHOTOS SUPPLIED BY ELAINE KLEMMENSEN

our brain operates in executive mode, it uses a lot of energy, essentially draining our battery. Creating space to activate the default mode network, which happens easily when bikepacking, gives our brain time to recharge, boosting our focus and performance when we return to work.

BELONGING AND COMMUNITY

Bikepacking with Eddie has been a catalyst for developing new friends around the world. There is nothing like a wiggly, tail-wagging ball of happiness to draw people in and start a conversation. And there is nothing more important to human thriving than feeling a sense of belonging and community. There are countless ways to find community, and doing what you love outdoors with man's best friend is a pretty great way to experience this important piece of the well-being puzzle.

AWE

Looking back on the highlight reel of one's life, it's those goosebump-inducing moments of wonder that stand out. A baby placed in their parent's arms. Standing in an old-growth forest, gazing up at giant cedars. Being transformed by music or art. Bikepacking isn't a prerequisite for awe, but stepping away from our phones and creating space for it to emerge certainly are. When researchers interviewed 320,500 people from 26 different countries about what brings them awe, not a single one mentioned their smartphone. Creating opportunities to bask in wonder and awe has been found to decrease markers for chronic inflammation, reduce ruminations, boost our mood, lessen impatience, expand our sense of time, and even humble us. And if that isn't enough, savouring just the memory of an awe-inspiring event also positively impacts our well-being.

As veterinary professionals, every day is an opportunity to support the human-animal bond. Sometimes we lose sight of our positive impact on the lives of our patients and the humans who love them. Reflecting on our relationships with the animals we cherish can be a powerful path back to what initially drew us to veterinary medicine. Since graduating from veterinary school, I've welcomed many dogs (and cats) into my life—from planned adoptions to rescues, mutts to purebreds—and each of them has a special place in my heart. Yet, somehow, my relationship with Eddie is different. Who knew I would fall so deeply in love with this scruffy little dog? Perhaps it's because he arrived at a point in my life when I had time to build the relationship he needed to become the sweet, confident boy who was hiding behind what looked like aggression, but was really fear and uncertainty. Time to train him to ride on a bicycle and sleep in a tent. Time to slow down and explore the world at a dog's pace—think sniffing, lots of sniffing! Beyond supporting key factors in my well-being, travel with Eddie has taught me to be more patient, more flexible, and more open to the unexpected. Things don't always go as planned, and yet we always figure it out. Sounds a lot like life in a veterinary hospital, doesn't it? I hope this article inspires you to pursue your own adventures, big or small, with your favourite furball, as you discover your personal recipe for resilience. WCV

"AS VETERINARY PROFESSIONALS, EVERY DAY IS AN OPPORTUNITY TO SUPPORT THE HUMAN-ANIMAL BOND."

DOGPACKING 101

Adventures with your dog should always be fun and safe for your pet. Consider your dog's temperament, personality, and physical abilities and pick an activity they will enjoy.

Take it slow. Introduce your dog to the new activity in stages and never force your dog. Make the experience positive and reward desired behaviour.

Be realistic about what your pet can do and plan accordingly. Condition your dog to ensure they are ready for physically demanding adventures and monitor them closely while engaging in the activity.

Plan ahead. Consider weather, road conditions, water, and food requirements, and carry a first aid kit for your pet. You may also want to carry a copy of their health and immunization records if spending multiple nights away from home.

Curious about adventuring with your pet?

Check out www.dogpacking.com, a website created by veterinarian Dr. Krista Halling that is full of resources to get you started.

CUT OUT THIS PAGE IF YOU WISH TO SAVE IT.

CASE COMMENT:
INFORMED CONSENT—THE ETHICAL AND LEGAL FOUNDATION TO VETERINARY PRACTICE

BY SCOTT NICOLL, BA, MA, LLB

British Columbia and Ontario comprise the vast majority of professional discipline cases in Canada, including veterinarian cases. Veterinarian and other professional regulatory bodies across the country will often consider and rely on decisions from other jurisdictions in support of their deliberations. This iteration of our column involves a review of a September 2023 decision of the College of Veterinarians of Ontario (CVO) that considers one of the most basic of professional obligations of medical and para-medical professionals: your obligation to obtain informed consent for any treatment.[1]

THE ISSUE

The straightforward issue in this case was this: did the veterinarian obtain sufficiently informed consent from their client? Beyond that, however, the decision is also instructive on the more specific question of what do you need to show that you have obtained the client's informed consent? More specifically still: what documents will be sufficient to show informed consent of the client? To find out, read on.

THE FACTS

The veterinarian in this case was employed for many years at an equine hospital located at an Ontario horse racetrack. The complaint related to allegations by a racehorse owner that the veterinarian did not keep proper records, did not obtain informed consent for the procedures performed, failed to communicate with their client about the procedures performed and the fees for the same, and administered unidentified substances to horses owned by the complainant.

The veterinarian, for their part, stated that they did in fact have informed consent, including the documentation in support of the same. Critically, however, and notwithstanding their claims, they were unable to produce such documentation to the regulator when requested to do so. Never a good starting point when you are the subject of a complaint to your regulator.

INFORMED CONSENT IN BRITISH COLUMBIA

The elements of informed consent will be well known to all medical and para-medical professionals. Veterinarians, specifically, will know that a statement of the same can be found at section 211 of your College's Bylaws.[2] Informed consent is the communication between you and the client that permits the client to understand your proposed veterinary services, following which the client voluntarily, and obviously not through misrepresentation or fraud, agrees to those services. To obtain informed consent, you must provide information that is sufficient to enable Lord Justice Greer's now storied reasonable person riding the Clapham omnibus to understand your proposed veterinary services.[3] You must also permit your client the meaningful opportunity to ask questions and to understand your answers about your proposed veterinary services. You must communicate with the client to confirm your proposed veterinary services. You should also provide information relating to your diagnosis or possible diagnoses; proposed treatments; any risks, benefits, and side effects; the alternative options and the risks and benefits of those alternative options; and, often very importantly, the consequences if treatment is denied. You should obviously answer all relevant questions and provide treatment fee estimates.

The client providing the consent must also have the legal authority to decide consent for the patient and be capable of deciding whether consent should be given for the proposed veterinary services. This means you need to make sure you are obtaining informed consent from the right person and that you document the same in your chart.

CVBC Bylaw s. 211(8) further stipulates that obtaining informed consent is an ongoing obligation and not a "one and done" obligation.[4] Critically, where you believe consent to have been subsequently revoked for any reason, you need to stop and re-confirm that consent before continuing treatment. The next question I always get is: "Well, what if that happens in the middle of a procedure and stopping could endanger the patient?" My answer to that is always that you must use your professional judgment. One option is for you to stop once you believe you can safely do so without unnecessarily or unreasonably endangering the patient, re-confirm your consent, and then continue. You should be careful to chart that re-confirmation of consent afterwards.

Those are the essential elements of informed consent in British Columbia. Specific circumstances inevitably give rise to further considerations and even accommodations, when warranted, as in the instance of revoked consent. The essential elements remain, however, and should be second nature to every veterinarian in practice.

THE DECISION

We know the veterinarian in this instance was unable to produce the documentation they said confirmed that informed consent was obtained from the client. Unsurprisingly, the Panel inferred from this failure to produce the documentation that either the documents did not exist or the registrant did not maintain sufficiently adequate clinical records in accordance with their professional standards.[5] Also unsurprisingly, the Panel then decided that either conclusion eliminated the possibility that sufficiently informed consent could be shown. Not that it had not been obtained, mind you, just that it could not be shown. Does this matter, enquiring minds ask? After all, the veterinarian says that they did obtain the informed consent and says that they did create the documentation. Should they just simply not be believed? Well as it turns out, in the face of a complaint, one will not simply be believed. You will need to be able to prove it when the client gives evidence to the contrary. You will need to have sufficiently clear and probative documentary evidence to confirm the same.

To be clear, it is not required in all circumstances that you must obtain written consent. That is not the case. Under both

Ontario and British Columbia practice standards, verbal or implied consent may be valid. The best practice when you obtain verbal consent, however, is also to have a witness to that consent, for what I hope are obvious reasons. Regardless of the format of the consent, it is imperative that you document the consent obtained in your clinical records, including how the consent was obtained. CVBC Bylaw s. 211(9)[6] and the CVO's Guide to the Professional Practice Standard[7] both say the same thing in this regard. While verbal consent can be valid, it is not best practice when written consent can be just as easily obtained. Unless circumstances (e.g., urgency) prevent it before treatment, obtain informed consent to procedures in writing.

You will already know that you are required to retain your clinical records for at least seven years under CVBC Bylaw s. 246(1).[8] Similarly, you will know that your records must meet certain minimum standards, including the requirement to document, maintain, and retain current and accurate medical information for each of your patients; ensure that it is a full record, is detailed, is in English, and is understandable. Anyone reading a medical record entry must also be able to know who wrote it. For further details on medical records, see CVBC Bylaw s.243 to s.247.[9] Regulators quite correctly take the view that your clinical records give context to your patient-care decision-making, the judgments made, and the communications had with clients. The Panel in this case specifically highlighted that medical records must be readily accessible and maintained in such a manner so as to be able to be used by other healthcare providers when necessary in order to permit continuity of care. As such, complete medical records provide the foundation to ethical and legal veterinary practice. This is the view your regulator will take when they review your records. This is also the view you should have when preparing and maintaining your records.

THE PANEL'S DECISION

If the veterinarian in this instance is to be believed, they obtained informed consent from the client in this case. However, their failure to keep proper records meant that they could not show that they did so. What is more, their record-keeping was such that they also lacked records describing the treatment provided, the costs of care, and administered medication. The lack of records eventually also adversely affected the patient's continuity of care. In keeping with the theme of this decision thus far, the Panel, unsurprisingly, determined that the veterinarian committed professional misconduct by not keeping proper records and failing to communicate with their clients on cost estimates for procedures or to document such communications. The Panel emphasized that the potential cost of veterinarian services must be made known to a client before informed consent can be obtained. This communication must also be documented in clinical records. None of which was done.

THE PENALTIES

The Panel assessed a number of penalties against the registrant in this case. They reprimanded the veterinarian for what they found to be a lack of basic record keeping. They suspended their license for two months, imposed licence conditions, including a requirement to complete continuing education courses on informed client consent and the foundations for medical record keeping in the equine industry. They also required the veterinarian to successfully complete four unannounced record reviews and half-day assessments to evaluate their knowledge on recordkeeping and professional fees following completion of the course. There would also be an additional assessment of the veterinarian's knowledge following completion of all the penalty conditions.

Not insignificantly, the member was required to pay $36,449.92 in costs to the CVO. The decision to assess costs arose due to the Panel's relative success in demonstrating that the veterinarian's record keeping practice was seriously deficient, the gravity of the misconduct, the hearing length, and the need to engage in a full contested hearing. The Panel found that the veterinarian minimized their misconduct in this instance, which the Panel considered to be "disgraceful and dishonourable." It would seem that the veterinarian appeared to be convinced of their relative lack of culpability to the end, something the CVO thought worthy of particular censure.

WHY IS THIS IMPORTANT TO YOU?

I trust it is obvious by this point why the two key points of this decision are important to you.

How you obtain informed consent matters. Obtain it in writing whenever possible. Have a witness record the consent when written consent is not possible. Always, and I mean always, chart how and that you obtained it, regardless of how it was obtained. Re-confirm it when you believe it may have been revoked. And know the elements of informed consent and ensure that is the consent you obtain.

How you create and maintain your clinical charts to record informed consent matters just as much to you as the consent itself. If you do not sufficiently attend to the former, you may be unable to establish the latter. Your records matter not only to you as tools for you in your practice. They matter to you when something goes wrong. Your clinical records are often your first and best line of defence when a complaint is made against you. When I first review the clinical records of a client who has become the subject of a complaint to the College, I will admit that I now quickly form an impression of the reliability of that client's evidence from their records. I also often form an impression from a review of those records as to whether the case is likely to resolve quickly or will prove detracted and difficult. That impression is the result of my experience defending professionals and using their clinical records as a critical tool to assist in the same. My experience is that your clinical records say as much to a third party about you as a professional as they say to you about the patient. You should always create and maintain them accordingly.

As always, this column is not legal advice and should not be construed as such. Information related to how informed consent is evidenced in a veterinary practice is provided in this column. This column does not provide a comprehensive review on informed consent. Each scenario is fact-specific. Please consult your legal counsel if you have any questions on this topic. WCV

[1] College of Veterinarians of Ontario. 23 September 2023. *Discipline Orders*, https://www.cvo.org/investigations-and-hearings/discipline-orders/dr-peter-vatcher.

[2] College of Veterinarians of British Columbia. 2023. *Bylaws Part 4 – Ethics and Standards*, s.211, https://www.cvbc.ca/wp-content/uploads/2023/11/Part-4-Ethics-and-Standards-Nov-2023-version-1.pdf. [CVBC Bylaws]

[3] Hall v. Brooklands Auto-Racing Club, [1933] 1 KB 205.

[4] CVBC Bylaws, supra note 2, s.211(8).

[5] College of Veterinarians of Ontario. Revised January 2022 (latest). Medical Records – Guide to the Professional Practice Standard, https://www.cvo.org/getmedia/21c320ef-f1f1-4c2a-9350-ef154d73f3bc/Guide-Medical-Records.pdf.

[6] CVBC Bylaws, *supra* note 2, *s.211(9)*.

[7] College of Veterinarians of Ontario. Revised April 2020. *Guide to the Professional Practice Standard – Informed Client Consent*, https://www.cvo.org/standards/guide-informed-client-consent.

[8] CVBC Bylaws, *supra* note 2, *s.246(1)*.

[9] CVBC Bylaws, *supra* note 2, s.243 to *s.247*.

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